

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy Q. Adams | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 2, 1981 | | | | 2b. HOUR M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR May 26, 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY) -95 94 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Florist | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William S. Quinn | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Clark | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 220-48-1907 | | 17. INFORMANT ADDRESS Victoria Adams 5900 Rampart #2153 Houston, Texas | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown (Believed to be Coronary occlusion)</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis and Atherosclerosis, generalized severe many years</u> DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Compression Fracture L4 (2) Osteoporosis marked (3) Prior myocardial infarction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (didn't) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>N. E. Lortbrun, Jr.</u> M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/5/81 | |
| 23a. FUNERAL HOME NAME (TYPE OR PRINT) <u>N. E. Lortbrun, Jr.</u> | | | | | | 23b. ADDRESS <u>144 Market St. Pocomoke, Md. 21851</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY Salem Meth. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md. | |
| 24. FUNERAL DIRECTOR NAME Scott S. Melton | | | | | | ADDRESS Pocomoke City, Md. | | 25a. DATE REC'D. BY REGISTRAR May 11 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-11-01 BY 60322

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

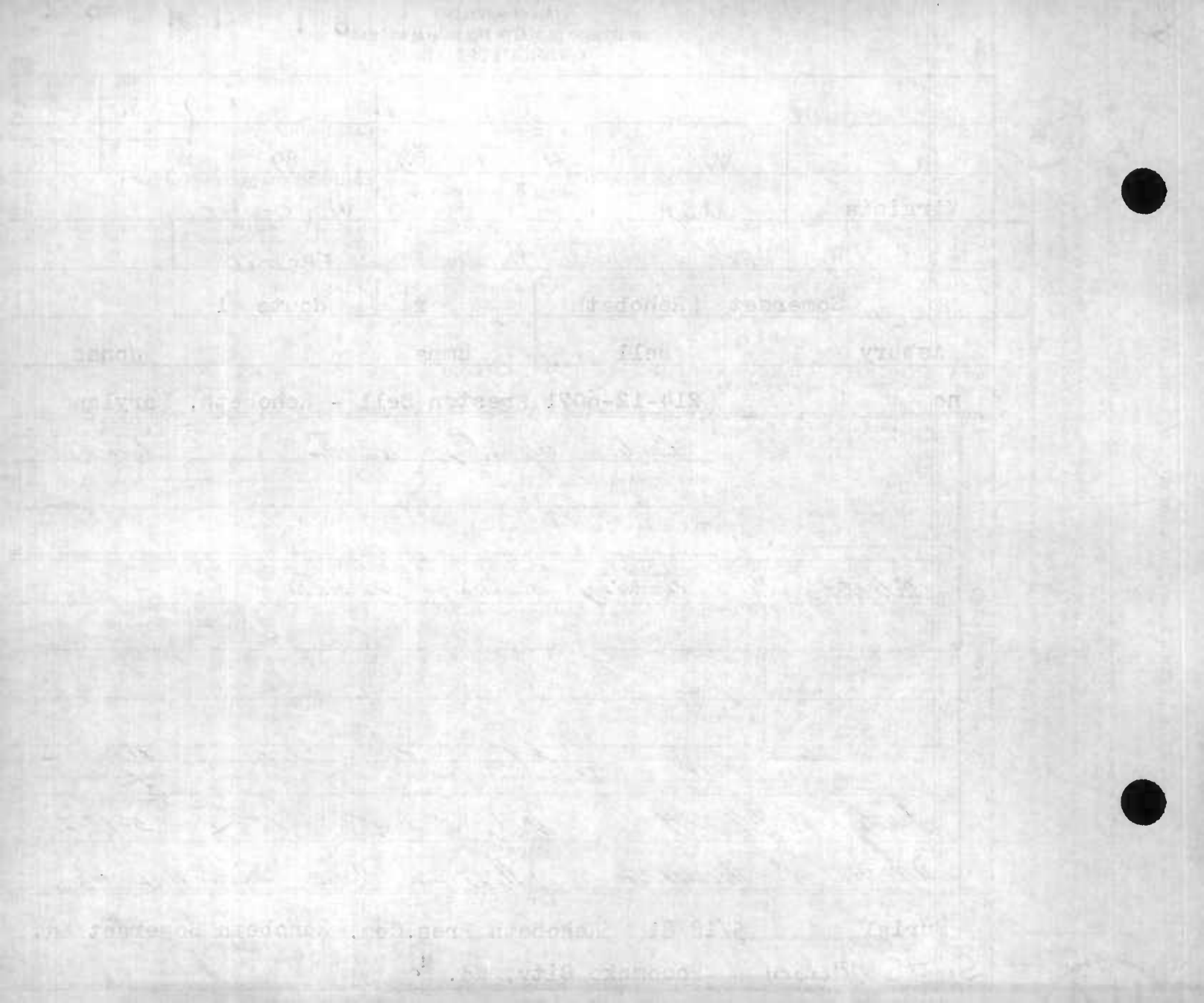
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|---|--------------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sidney C. Bell</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>5 15 81</i> | | | 2b. HOUR <i>2:30</i> A.M. | | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>4 1 1892</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Worcester</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Snow Hill, Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harrison House Nursing Home</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE <i>Md.</i> | | | | | 13b. COUNTY <i>Somerset</i> | | 13c. CITY OR TOWN <i>Rehobeth</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Asbury Bell</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Jones</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>214-12-6071</i> | | 17. INFORMANT ADDRESS <i>Preston Bell - Rehobeth, Maryland</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Metastatic Ca secondary anemia, malnutrition</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>5-4</i> 19 <i>81</i> , to <i>5-15</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>5-14</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Dorothy C. Holzworth</i> | | | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>5-17-81</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dorothy C. Holzworth</i> | | | | 22e. ADDRESS <i>Harrison House Snow Hill, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>5/18/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rehobeth Pres. Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rehobeth Somerset Md.</i> | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Scott S. Nelson</i> | | | | ADDRESS <i>Pocomoke City, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>MAY 22 1981</i> | | 25b. REGISTRAR'S SIGNATURE | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|--------------------------------------|--|---|--|--------------------------------|--|--|--|----------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | | |
| Lucius | | Brown | | Jr. | | | | 5-10-81 | | | | 4P | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | 7d. HOUR | | | |
| Male | Negro | 8-21-1931 | | 49 YRS. | | | | | | 5-10-81 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Ga. | | U.S.A. | | WIDOWED | | DIVORCED | | Worcester | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Pocomoke City | | At Home | | Rute #1 Box 429 | | Laborer | | Construction | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | Wor. | | Pocomoke City | | YES | | NO | | R.F.D. 1 Box 429 | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| Lucius | | Brown | | Sr. | | Annie Lou. | | Wooten | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 255-46-9251 | | Catherine Schoolfield, Pocomoke, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 4100 IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. DEPUTY | | | | MEDICAL EXAMINER | | | | DATE SIGNED 5-15-81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | J. G. SANTIAGO | | | | ADDRESS, 100 8th St Pocomoke City | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 5-16-81 | | | | Arlington | | | | Pocomoke Md. 02nd | | | | | |
| 24. FUNERAL DIRECTOR (NAME) | | | | 25a. DATE RECEIVED BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Samuel Lange | | | | MAY 20 1981 | | | | | | | | | | | | | |

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18-21-7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 4 3 6 4 | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | REG. NO. | | | |
| NELL CHRISTIE | | | | MAY 26 81 | | | | 10:10 P ^M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MAY 10 - 14 - '93 | | 6. AGE (IN YEARS-LAST BIRTHDAY) 87 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BERLTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. STATE MD. | | | | 13b. COUNTY WORCESTER | | 13c. CITY OR TOWN BERLIN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James C. Seetin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Shilling | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 447-30-7698 | | | | 17. INFORMANT Jeanne V. Green, Berlin, MD | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Alma W. Lawrence MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-29-81 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester MD | | | |
| 24. FUNERAL DIRECTOR NAME <u>Charles W. Hastings, Solbyville, DE</u> | | | | ADDRESS <u>Solbyville, DE</u> | | | | 25a. DATE REC'D. JUN 1 1981 | | | |

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James V. Green, Berlin, MD

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5-2-77

James V. Green, Berlin

Berlin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | 2b. HOUR |
| 1 DECEASED NAME (TYPE OR PRINT) Edward James Collins | | | MONTH DAY YEAR May 15, 1981 | | 12:00 A |
| 3 SEX Male | 4 RACE Caucasian | 5 DATE OF BIRTH MONTH DAY YEAR July 10 1923 | 6 AGE (IN YEARS LAST BIRTHDAY) 57 | | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | |
| 10 CITY OR TOWN OF DEATH Berlin | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Griffin Rd. Rt 2 Box 613 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Gen'l. Hauling | |
| 13a. STATE Md. | 13b. COUNTY Worcester | 13c. CITY OR TOWN Berlin | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Griffin Road | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James B. Collins | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delaphine - Hudson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | |
| 16b. SOCIAL SECURITY NO 12/30/48-1950 220-12-0288 | | 17 INFORMANT ADDRESS Beatrice P. Collins Rt 2 Box 613 Berlin Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) congestive heart failure, prostate adenocarcinoma | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from Sept 19 81 to May 15 19 81 , that (I) was last saw the deceased alive on May 8 19 81 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Rodney A W Enrich | | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH | | 22e. ADDRESS KAY AVE. SALISBURY MD 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 5/17/81 | 23c. NAME OF CEMETERY OR CREMATORY Taylorville Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md. | | |
| 24 FUNERAL DIRECTOR NAME Anna D. Burdage ADDRESS Berlin Md. | | 25a. DATE REC'D BY REGISTRAR MAY 23 1981 | | 25b. REGISTRAR'S SIGNATURE | |

BP _____

Edward James Callaghan
March 10, 1973
M.I.
The White House
Washington, D.C.
Dear Mr. Callaghan:
I am pleased to hear
of your recent return
from Europe. I hope
you had a very
enjoyable trip.

I am sure you will
be able to tell me
all the news from
Europe. I am
looking forward to
hearing from you
again soon.
Very truly,
Richard M. Nixon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUTH ANN DAVIS | | | 2a. DATE OF DEATH MONTH MAY DAY 8 YEAR 1981 | | | 2b. HOUR 3 MIN 5 PM | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 1 DAY 28 YEAR 89 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BERLIN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 S. MAIN ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY — | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY WOR | | 13c. CITY OR TOWN BERLIN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 203 S. MAIN ST. | | | |
| 14. FATHER'S NAME FIRST JAMES MIDDLE NEWTON LAST — | | | | | | 15. MOTHER'S MAIDEN NAME FIRST HANNAH MIDDLE LEONARD LAST — | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. MD-50-2748 | | 17. INFORMANT ADDRESS EVELYN LAGER BERLIN, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EXTREME CACHEXIA (c) FAR-ADVANCED METASTATIC ADENOCARCINOMA OF COLON | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR — A.M. — MONTH 11 DAY 1 YEAR 19 P.M. — | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE — | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/1 , 19 80 , to 5/8 , 19 81 , that (1) (we) lost saw the deceased alive on 5/6 , 19 81 , and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Paul A. Scott, M.D. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/9/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, M.D. | | | | 22e. ADDRESS 24 BROAD ST, BERLIN, MD. 21811 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5-13-81 | | 23c. NAME OF CEMETERY OR CREMATORY SKY VIEW M.P. | | 23d. LOCATION CITY OR TOWN NOTETOWN, SKY, PA. COUNTY — STATE — | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM FUNERAL HOME | | | | ADDRESS BERLIN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 18 1981 | | 25b. REGISTRAR'S SIGNATURE — | |

12

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

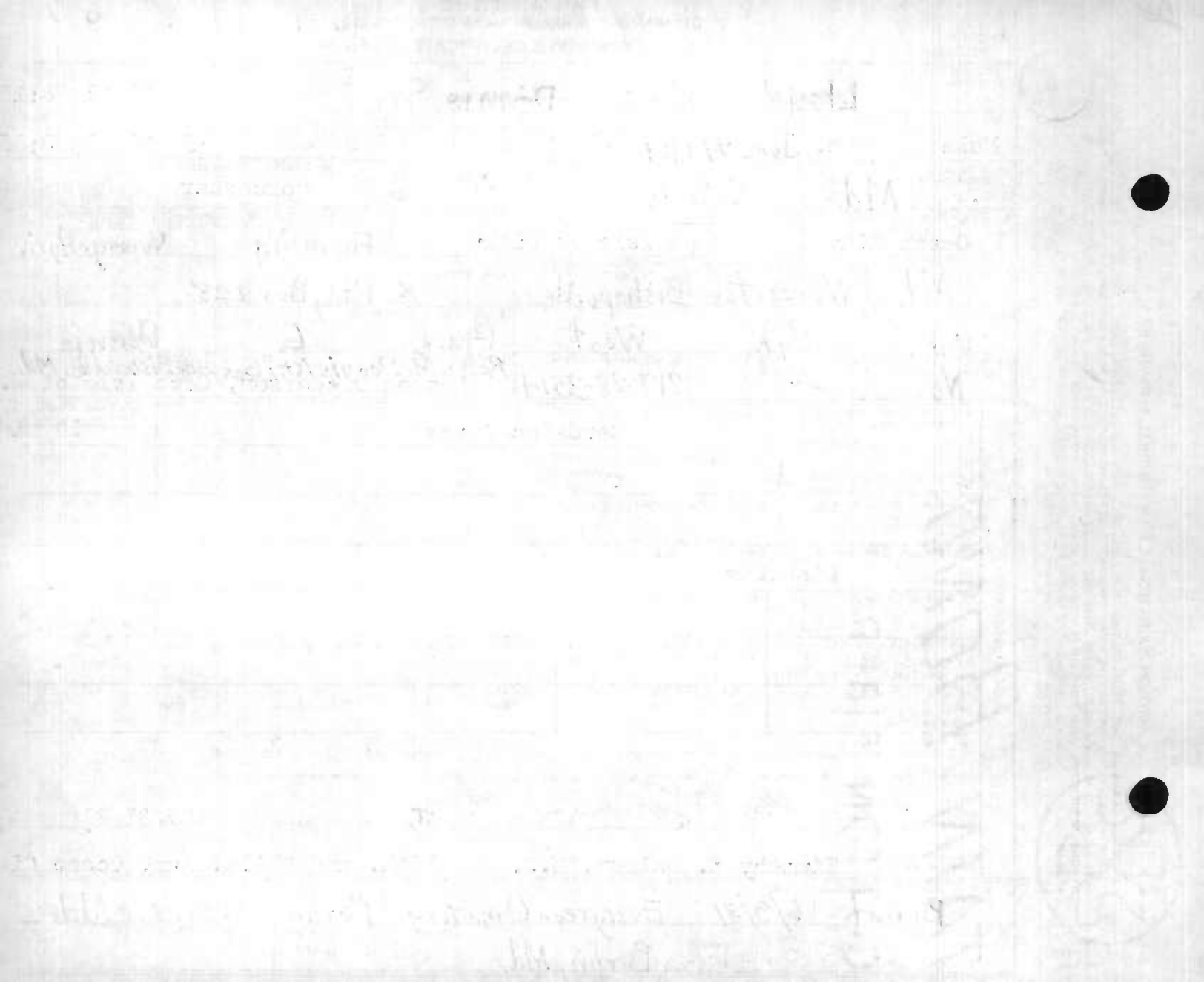
UNIVERSITY OF CHICAGO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) Lloyd West Dennis, Sr. | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 31 1981 | | 2c. HOUR 8:15 | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH June DAY 29 YEAR 1919 | | 6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS. | | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | 7. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | |
| 10. CITY OR TOWN OF DEATH Ocean City | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cape Isle of Wight | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming | | 12b. KIND OF BUSINESS OR INDUSTRY Nursery & Agri. | |
| 13a. STATE Md. | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Bishopville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1, Box 228 | | | |
| 14. FATHER'S NAME FIRST Unk. MIDDLE Unk. LAST West | | | | 15. MOTHER'S MAIDEN NAME FIRST Grace MIDDLE L. LAST Dennis | | | | 16. SOCIAL SECURITY NO. 217-28-3514 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 217-28-3514 | | | | 16c. ADDRESS Reba M. Dennis Rt. 1 Box 228 Bishopville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4292 (b) CVHD (c) CVHD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Timothy E. Bainum | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Timothy E. Bainum, M.D. | | | | ADDRESS 16th. and Phila. Ave. Ocean City | | | | DATE SIGNED 5/31/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6/3/81 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | | | 23d. LOCATION CITY OR TOWN Berlin COUNTY Wor. STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Anna A. B. Wells ADDRESS Berlin, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1981 | | | | 25b. REGISTRAR SIGNATURE | | | |



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 1 1 4 3 6 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) (MARY) GRACE (ELLIOTT) Elliott | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 6 81 | | | 2b. HOUR 6:20 AM | |
| 3 SEX female | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6 7 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD. | |
| 10. CITY OR TOWN OF DEATH Berlin | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY - - - - | | 13a. STREET ADDRESS 60 Somers Cove Apts. | | | | | |
| 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 13c. CITY OR TOWN Crisfield | | | | | | | |
| 13d. COUNTY Somerset | | | | | | | |
| 13e. STATE Md. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roland Matthews | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elnora Miller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none | | | | 16b. SOCIAL SECURITY NO. 218-34-7868 | | | |
| 17. INFORMANT Robert J. Elliott, Jr. | | | | ADDRESS Rt. 1 Box 436 A Crisfield, Md. 21817 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (b) C.H.I.P. DUE TO, OR AS A CONSEQUENCE OF: (c) Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Francis Warren, MD. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS HAYES LANDING - BERLIN, MD. 21811 | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Bradshaw & Sons Crisfield, Md. 21817 | | | | 25a. DATE REC'D. BY REGISTRAR MAY 11 1981 | | 25b. REGISTRAR'S SIGNATURE Richard McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-100000-1000

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-00 BY 100000-1000

REASON: 100000-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Levina Tull Hargis | | 2a. DATE OF DEATH MONTH DAY YEAR May 18, 1981 | | 2b. HOUR 5 a. | |
| 3 SEX Female | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR May 15, 1906 | 6 AGE (IN YEARS LAST BIRTHDAY) 75 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcestor | | |
| 10 CITY OR TOWN OF DEATH Pocomoke | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home 6th. Street | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory | 12b KIND OF BUSINESS OR INDUSTRY Chicken Plant | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. | | 13b COUNTY Worcestor | 13c CITY OR TOWN Pocomoke | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS 6th. Street |
| 14 FATHER'S NAME FIRST MIDDLE LAST Adolphus Tull | | 15 MOTHER'S MAIDEN NAME FIRST LAST Drucilla Spencer | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO 219-07-0516 | 17 INFORMANT ADDRESS Alonza Tull--Pocomoke, Maryland | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY 1539 IMMEDIATE CAUSE (a) Carcinoma of the Colon | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF With generalized metastasis (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 5-1- 19 79 , to 5-18- 19 81 , that (I) (we) last saw the deceased alive on 5-18-81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE J. G. Santiano | | DEGREE | | 22c DATE SIGNED 5-22-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) J. G. Santiano, M.D. | | 22e ADDRESS 100 8th St., Pocomoke City, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE May 24, 1981 | 23c NAME OF CEMETERY OR CREMATORY Halls Hill | | 23d LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcestor, Md. |
| 24 FUNERAL DIRECTOR Accomac, Virginia | | 25a DATE REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |

BP

0170-12-712

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Thomas Howard | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 5 26 81 4:15 AM | | | | |
| 3. SEX Male | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 8 28 1898 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD. | | | |
| 10. CITY OR TOWN OF DEATH BERLIN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURS. HOME | | 12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Jewelry | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY ANNE AR. 13c. CITY OR TOWN Glen Burnie | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 6404 Shelley Road. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jessie Howard | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Anderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 215-07-5003 | | 17. INFORMANT ADDRESS Franklin Howard 427 Sylvian Drive Pasadena, Md. 21122 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Francis Warren | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-26-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS WARREN, MD | | | | | 22e. ADDRESS Berlin Nursing Home. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/29/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Anne Arundel, Md. | | |
| 24. FUNERAL DIRECTOR NAME Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 27 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 14371 | | | |
|---|--|---|--|---|--|---|--|------------------------------------|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| MATTIE CATHERINE LEWIS | | | | 5-15-81 | | | | 8:30 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| Female | | Caucasian | | May 17, 1911 | | 69 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MONTHS | | 10. DAYS | |
| Md. | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Worcester Co., MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| Berlin | | Stephen Decatur High School Road | | Housewife | | Home | | Rt 2, Box 84 A Stephen Decatur Rd. | | Berlin | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. CITY OR TOWN | |
| Md. | | Worcester | | Berlin | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt 2, Box 84 A Stephen Decatur Rd. | | Berlin | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | |
| William | | Edith | | No | | 217-12-4876 | | William C Timmons | | Rt. 2, Box 84 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1. DEATH WAS CAUSED BY | | | | 0 20 min | | | | | | | |
| IMMEDIATE CAUSE (a): | | | | Acute MYOCARDIAL INFARCTION | | | | | | | |
| 4100 | | | | Acute Myocardial Infarction | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | Arteriosclerosis | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | Arteriosclerosis | | | | years | | | |
| (b): | | | | | | | | | | | |
| (c): | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| OBESITY, HYPERTENSION, MATURE ONSET HYPERGLYCEMIA. | | | | | | | | | | | |
| 19a. OPERATIONS, TREATMENTS, OR OTHER PROCEDURES FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| N/A | | | | | | | | | | | |
| 19b. FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. TIME OF INJURY | | | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| P.M. 19 | | | | | | | | | | | |
| 21a. INJURY OCCURRED | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | | | | | | | | |
| AT WORK AT WORK | | | | | | | | | | | |
| 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. LOCATION | | | | | | | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1979, 19, to April 25, 1981, that (I) (we) last saw the deceased alive on April 25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | |
| Henry Clay Reister III, M.D. | | | | | | | | | | | |
| 22c. DEGREE | | | | | | | | | | | |
| M.D. | | | | | | | | | | | |
| 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | | | |
| Box 470, Berlin, Maryland 21811 | | | | | | | | | | | |
| 22f. DATE SIGNED | | | | | | | | | | | |
| 5/15/81 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | |
| Burial | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | |
| 5/19/81 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | |
| New Hope Cemetery | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Willards Wicomico Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | | | |
| Anne A. Burbank Berlin, Md. | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | |
| MAY 21 1981 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

1990

5. *Chloroceryle alpestris*

Henry Clay, 1806-1820, 1823-1825, 1827-1830, 1832-1834, 1836-1838, 1840-1842, 1844-1846, 1848-1850, 1852-1854, 1856-1858, 1860-1862, 1864-1866, 1868-1870, 1872-1874, 1876-1878, 1880-1882, 1884-1886, 1888-1890, 1892-1894, 1896-1898, 1900-1902, 1904-1906, 1908-1910, 1912-1914, 1916-1918, 1920-1922, 1924-1926, 1928-1930, 1932-1934, 1936-1938, 1940-1942, 1944-1946, 1948-1950, 1952-1954, 1956-1958, 1960-1962, 1964-1966, 1968-1970, 1972-1974, 1976-1978, 1980-1982, 1984-1986, 1988-1990, 1992-1994, 1996-1998, 2000-2002, 2004-2006, 2008-2010, 2012-2014, 2016-2018, 2020-2022, 2024-2026, 2028-2030, 2032-2034, 2036-2038, 2040-2042, 2044-2046, 2048-2050, 2052-2054, 2056-2058, 2060-2062, 2064-2066, 2068-2070, 2072-2074, 2076-2078, 2080-2082, 2084-2086, 2088-2090, 2092-2094, 2096-2098, 2100-2102, 2104-2106, 2108-2110, 2112-2114, 2116-2118, 2120-2122, 2124-2126, 2128-2130, 2132-2134, 2136-2138, 2140-2142, 2144-2146, 2148-2150, 2152-2154, 2156-2158, 2160-2162, 2164-2166, 2168-2170, 2172-2174, 2176-2178, 2180-2182, 2184-2186, 2188-2190, 2192-2194, 2196-2198, 2200-2202, 2204-2206, 2208-2210, 2212-2214, 2216-2218, 2220-2222, 2224-2226, 2228-2230, 2232-2234, 2236-2238, 2240-2242, 2244-2246, 2248-2250, 2252-2254, 2256-2258, 2260-2262, 2264-2266, 2268-2270, 2272-2274, 2276-2278, 2280-2282, 2284-2286, 2288-2290, 2292-2294, 2296-2298, 2300-2302, 2304-2306, 2308-2310, 2312-2314, 2316-2318, 2320-2322, 2324-2326, 2328-2330, 2332-2334, 2336-2338, 2340-2342, 2344-2346, 2348-2350, 2352-2354, 2356-2358, 2360-2362, 2364-2366, 2368-2370, 2372-2374, 2376-2378, 2380-2382, 2384-2386, 2388-2390, 2392-2394, 2396-2398, 2400-2402, 2404-2406, 2408-2410, 2412-2414, 2416-2418, 2420-2422, 2424-2426, 2428-2430, 2432-2434, 2436-2438, 2440-2442, 2444-2446, 2448-2450, 2452-2454, 2456-2458, 2460-2462, 2464-2466, 2468-2470, 2472-2474, 2476-2478, 2480-2482, 2484-2486, 2488-2490, 2492-2494, 2496-2498, 2500-2502, 2504-2506, 2508-2510, 2512-2514, 2516-2518, 2520-2522, 2524-2526, 2528-2530, 2532-2534, 2536-2538, 2540-2542, 2544-2546, 2548-2550, 2552-2554, 2556-2558, 2560-2562, 2564-2566, 2568-2570, 2572-2574, 2576-2578, 2580-2582, 2584-2586, 2588-2590, 2592-2594, 2596-2598, 2600-2602, 2604-2606, 2608-2610, 2612-2614, 2616-2618, 2620-2622, 2624-2626, 2628-2630, 2632-2634, 2636-2638, 2640-2642, 2644-2646, 2648-2650, 2652-2654, 2656-2658, 2660-2662, 2664-2666, 2668-2670, 2672-2674, 2676-2678, 2680-2682, 2684-2686, 2688-2690, 2692-2694, 2696-2698, 2700-2702, 2704-2706, 2708-2710, 2712-2714, 2716-2718, 2720-2722, 2724-2726, 2728-2730, 2732-2734, 2736-2738, 2740-2742, 2744-2746, 2748-2750, 2752-2754, 2756-2758, 2760-2762, 2764-2766, 2768-2770, 2772-2774, 2776-2778, 2780-2782, 2784-2786, 2788-2790, 2792-2794, 2796-2798, 2800-2802, 2804-2806, 2808-2810, 2812-2814, 2816-2818, 2820-2822, 2824-2826, 2828-2830, 2832-2834, 2836-2838, 2840-2842, 2844-2846, 2848-2850, 2852-2854, 2856-2858, 2860-2862, 2864-2866, 2868-2870, 2872-2874, 2876-2878, 2880-2882, 2884-2886, 2888-2890, 2892-2894, 2896-2898, 2900-2902, 2904-2906, 2908-2910, 2912-2914, 2916-2918, 2920-2922, 2924-2926, 2928-2930, 2932-2934, 2936-2938, 2940-2942, 2944-2946, 2948-2950, 2952-2954, 2956-2958, 2960-2962, 2964-2966, 2968-2970, 2972-2974, 2976-2978, 2980-2982, 2984-2986, 2988-2990, 2992-2994, 2996-2998, 3000-3002, 3004-3006, 3008-3010, 3012-3014, 3016-3018, 3020-3022, 3024-3026, 3028-3030, 3032-3034, 3036-3038, 3040-3042, 3044-3046, 3048-3050, 3052-3054, 3056-3058, 3060-3062, 3064-3066, 3068-3070, 3072-3074, 3076-3078, 3080-3082, 3084-3086, 3088-3090, 3092-3094, 3096-3098, 3100-3102, 3104-3106, 3108-3110, 3112-3114, 3116-3118, 3120-3122, 3124-3126, 3128-3130, 3132-3134, 3136-3138, 3140-3142, 3144-3146, 3148-3150, 3152-3154, 3156-3158, 3160-3162, 3164-3166, 3168-3170, 3172-3174, 3176-3178, 3180-3182, 3184-3186, 3188-3190, 3192-3194, 3196-3198, 3200-3202, 3204-3206, 3208-3210, 3212-3214, 3216-3218, 3220-3222, 3224-3226, 3228-3230, 3232-3234, 3236-3238, 3240-3242, 3244-3246, 3248-3250, 3252-3254, 3256-3258, 3260-3262, 3264-3266, 3268-3270, 3272-3274, 3276-3278, 3280-3282, 3284-3286, 3288-3290, 3292-3294, 3296-3298, 3300-3302, 3304-3306

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR 415 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 4 3 7 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

DALTON

MARSHALL

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOURESTIMATED ☐ 5-19-81, 8:45 AM

3. SEX

male

4. RACE

black

5. DATE OF BIRTH

Feb. 12 1925

56 YRS.

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

5-19-81, 8:45 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Worcester County MD.

10. CITY OR TOWN OF DEATH

Pocomoke

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

602 Clarke Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Laborer

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Worcester

13c. CITY OR TOWN

Pocomoke

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

602 Clarke Ave.

14. FATHER'S NAME

Joshua

MIDDLE

Marshall

15. MOTHER'S MAIDEN NAME

Florence

MIDDLE

Holland

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE COMB. NO. (IF YES, GIVE WAR OR DATES))

No

16b. SOCIAL SECURITY NO.

215-20-0074A

17. INFORMANT

Robert Marshall

ADDRESS

438 Bank St. Pocomoke, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cirrhosis of liver

5715

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on

☒ Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Margarita A. Korell

M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED

5-19-81

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

5-23-81

23c. NAME OF CEMETERY OR CREMATORY

Mt. Hope Cem.

23d. LOCATION (CITY OR TOWN)

Stockton

COUNTY

Wor. Md.

24. FUNERAL DIRECTOR

NAME

New Church, Va.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

MAY 26 1981

25b. REGISTRAR'S SIGNATURE

Margarita A. Korell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

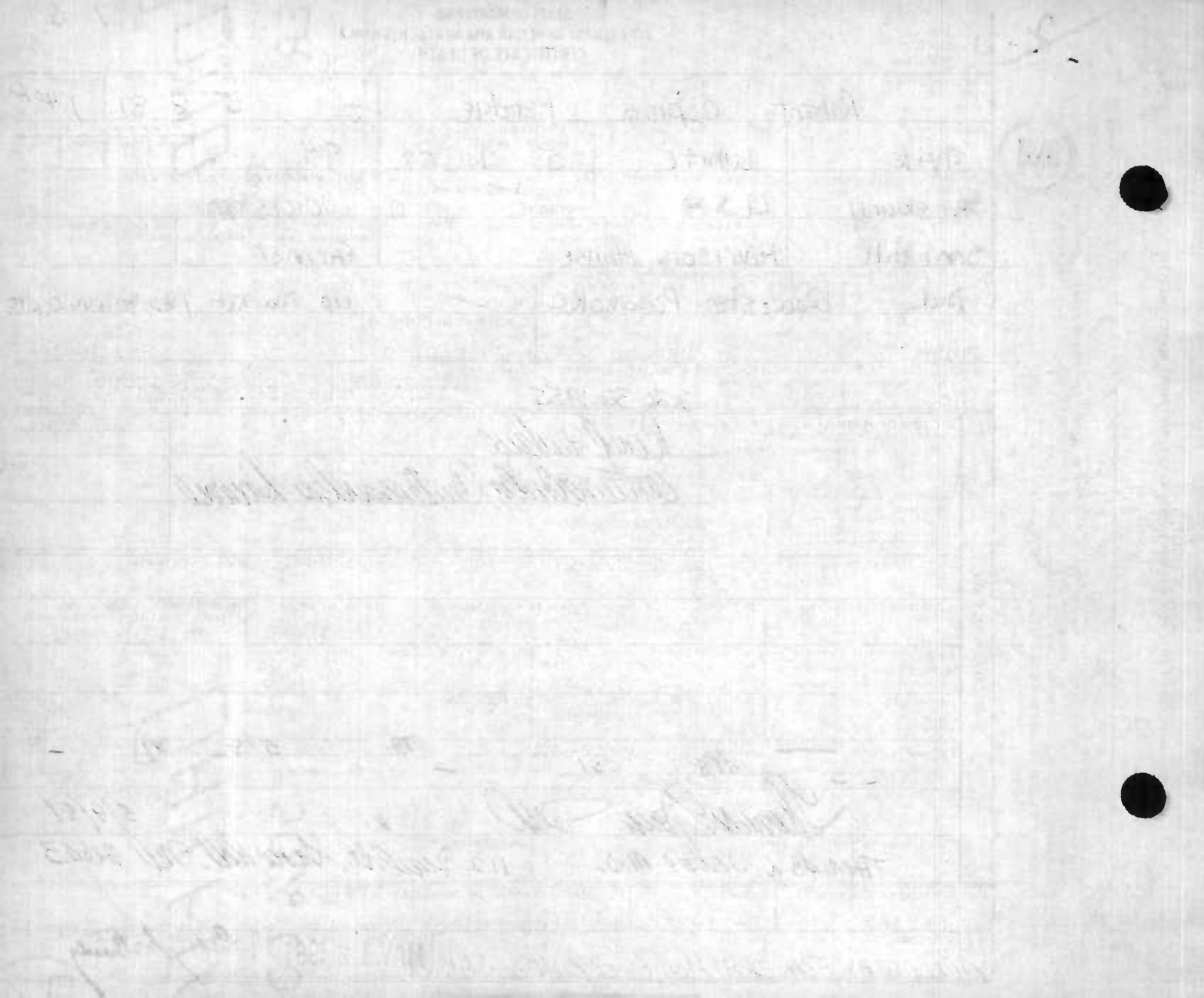
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Cepha Perdue | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 5 8 81 | | | 2b. HOUR MIN 1 40 P M | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 1 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | |
| 10. CITY OR TOWN OF DEATH Shore Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Purnell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Ann Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220 32 1455 | | 17. INFORMANT NAME ADDRESS Mrs. Laura Johnson Perdue 1210 Market St. Apt 6B Pocomoke, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Card Failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b): Chronic Coronary Artery Disease (c): Due to: OR AS A CONSEQUENCE OF | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (was hospital) attended the deceased from 1-22 , 19 79 , to 5/5 , 19 81 , that (I) (was) last saw the deceased alive on 5/8 , 19 81 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas L. Jones M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 5/9/81 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS L. JONES-M.D. | | | | 22d. ADDRESS 112 Pearl St. Shore Hill, Md. 21863 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-11-81 | | 23c. NAME OF CEMETERY OR CREMATORY Walston Switch Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bethel Nicomac Maryland | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR MAY 12 1981 | | | |



IMPORTANT: If item 1 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 4 3 7 4

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Harvey C. Pusey | | 2a. DATE OF DEATH MONTH DAY YEAR May 4, 1981 | | 2b. HOUR MIN. 12:15 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1899 | |
| 6. AGE (IN YEARS - LAST BIRTHDAY) 81 | | 7. BALTIMORE CITY OR COUNTY OF DEATH Worcester | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 9c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | |
| 10. CITY OR TOWN OF DEATH Snow Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 W. Martin St. | | 12. KIND OF BUSINESS OR INDUSTRY Insurance | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willard Lowe Pusey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Butler | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR YEARS) Yes WWII | |
| 17. SOCIAL SECURITY NO. 212 16 7292 | | 18. INFORMANT Frances H. Pusey | | 19. ADDRESS Snow Hill, Md. | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Intestine 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Colic DUE TO, OR AS A CONSEQUENCE OF (c) Colic | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 22a. DATE OF OPERATION | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 25. I certify that (I) (this hospital) attended the deceased from 12/10 , 19 80 , to 5/4 , 19 81 , that (I) have lost saw the deceased alive on 5/4 , 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) have (did) view view the body after death. | | | | | |
| 26. SIGNATURE Thomas H. Jones | | 27. FREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 28. DATE SIGNED 5/5/81 | |
| 29. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS H. JONES, M.D. | | 30. ADDRESS 112 PEARL ST., SNOW HILL, MD. 21863 | | | |
| 31. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 32. DATE 5-7-81 | | 33. NAME OF CEMETERY OR CREMATORY Whitcomb Meth. | |
| 34. FUNERAL DIRECTOR NAME Norman F. Dennis | | 35. ADDRESS Snow Hill, Md. | | 36. REGISTRY BY REGISTRY <input type="checkbox"/> REGISTRAR'S SIGNATURE | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

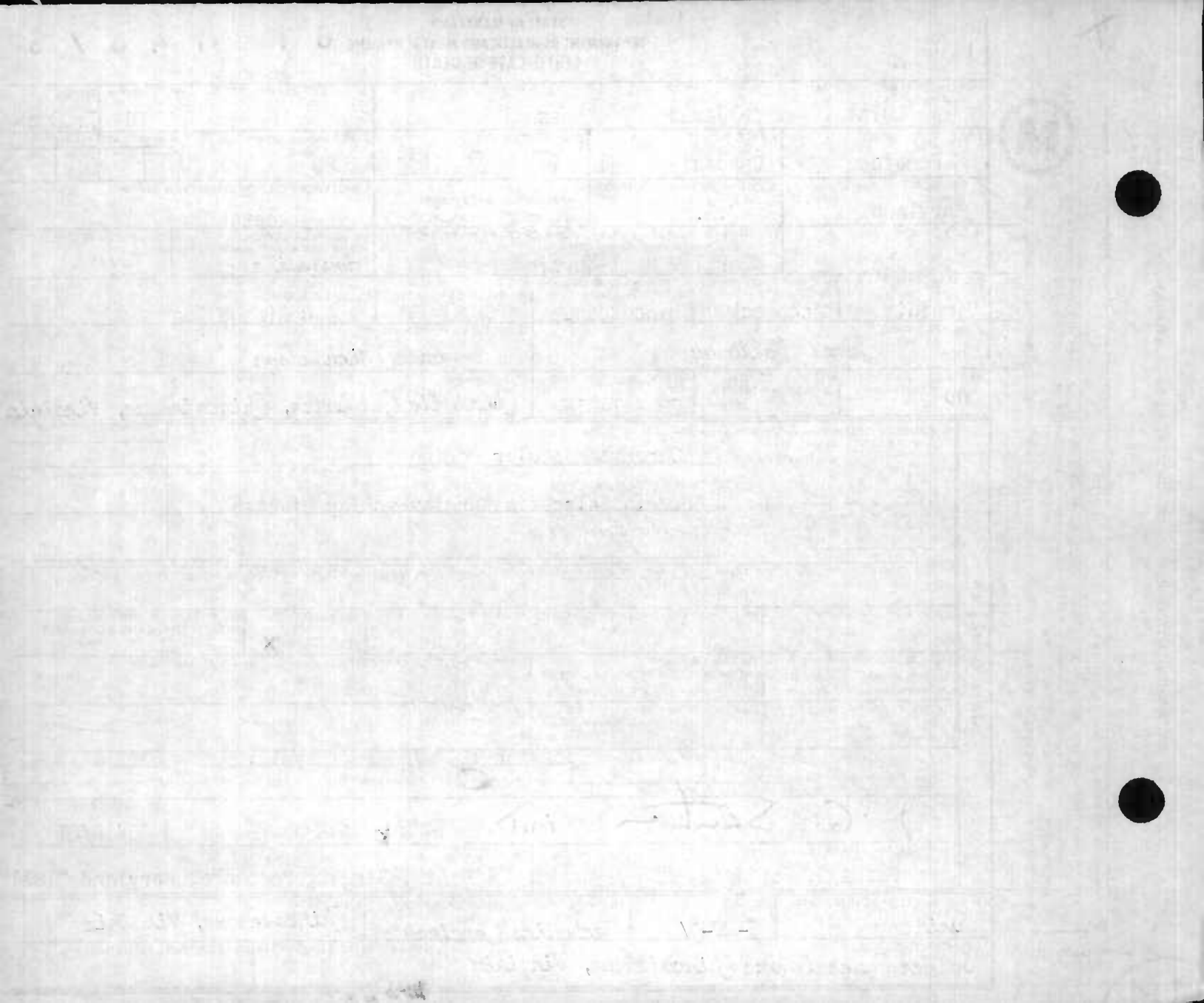
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 1 4 3 7 5 | |
|--|--|--|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lula James Russell | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 05 19 81 | | 2b. HOUR 7:00 p.m. | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 10 26 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Self | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia | | | | | | 13b. COUNTY Accomack | | 13c. CITY OR TOWN Chincoteague | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Holloway | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aranda Richardson | | 13d. STREET ADDRESS 448 Ridege Road | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-07-3184 | | 17. INFORMANT ADDRESS Charlotte Carpenter, Chincoteague, Virginia | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardiovascular Disease (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 12, 1979, to May 19, 1981, that (I) (we) lost saw the deceased alive on May 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. G. Santiano | | | | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 05/19/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jesus G. Santiano, MD | | | | 22e. ADDRESS 100 8th. Street, Pocomoke, Maryland 21851 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-22-81 | | 23c. NAME OF CEMETERY OR CREMATORY Mechanics Cemetery | | 23d. LOCATION Chincoteague, Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME Sayer Funeral Home Chincoteague, Virginia | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 1 4 3 7 6 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST MATTIE PORTER SATCHELL | | | | | MONTH DAY YEAR May 25, 1981 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| female | | | | | white | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | | | |
| MONTH DAY YEAR April 13, 1881 | | | | | 100 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Stockton, Wisc. | | | | | USA | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | Worcester MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Pocomoke | | | | | (residence) Newtown Apts. | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| housewife | | | | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | |
| Maryland | | | | | Worcester | | | | |
| 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| Pocomoke | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET ADDRESS | | | | | 13f. STREET ADDRESS | | | | |
| Newtown Apartments | | | | | Newtown Apartments | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| James H. Porter | | | | | Isabelle Waters | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| no | | | | | 220-52-8057 | | | | |
| 17. INFORMANT ADDRESS | | | | | 17. INFORMANT ADDRESS | | | | |
| Pearl Matthews | | | | | Newtown Apartments Pocomoke City, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure due to pulmonary fibrosis.</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis, chronic</u> (b) <u>severe and generalized and</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia twice this past winter.</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| | | | | | | | | | |
| 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| N.E. Sartorius, Jr. | | | | | 5/27/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| N.E. Sartorius, Jr., M.D. | | | | | 114 Market Street, Pocomoke | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | | | |
| Burial | | | | | 5/28/81 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Pitts Creek Pres. | | | | | Pocomoke Worcester Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25. DATE REC'D. BY REGISTRAR | | | | |
| Scott S. Melson | | | | | JUN 1 1981 | | | | |
| ADDRESS | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Pocomoke City, Md. | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 4 3 7 7 | |
|--|---|---|---|--|---|
| FOR 1 - STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LEILA Fisher SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/7/81 | | 2b. HOUR 4 A.M. |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 2 10 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? WICOMICO | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | |
| 10. CITY OR TOWN OF DEATH BERLIN | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY Gar. Factory |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD. | 13b. COUNTY WICO. | 13c. CITY OR TOWN HEBRON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS BOX 342 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis J.. Fisher | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Annie Hurley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. -- 215-03-0193 | 17. INFORMANT Mrs Ada L. Wright | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Hepatic insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the liver DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23a. SIGNATURE Francis Warren | | DEGREE MD | | 23c. DATE SIGNED 5-7-1981 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS WARREN, MD | | 23d. ADDRESS BERLIN NURS. HOME | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5-9-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron, Wicomico, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | ADDRESS Salisbury, Maryland | | 25. DATE REC'D. BY REGISTRAR MAY 11 1981 | |
| 26. REGISTRAR'S SIGNATURE | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 4 3 7 8
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) INGA K. TUBBS | | | 2a. DATE OF DEATH MONTH DAY YEAR MAY 17, 1981 | | | 2b. HOUR 12:50 P.M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 15, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | |
| 10. CITY OR TOWN OF DEATH BERLIN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POST MASTER | | 12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE | | | 13b. CITY OR TOWN SUSSEX | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS SOUTH MAIN ST. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. NEWCOMB | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA WHITE MAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 221-30-5576 | | 17. INFORMANT ADDRESS GLENDA J. LONG, SELBYVILLE, DE. | | | | | |

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|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22a. SIGNATURE <i>Heavenly Bodies</i> | | 22b. ADDRESS | |
| 22c. DATE SIGNED 5-17-81 | | | |

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|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY REDMEN'S CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SELBYVILLE SUSSEX DE | |
| 24. FUNERAL DIRECTOR <i>Charles W. Hartung</i> | | ADDRESS Selbyville, Del | | 25a. DATE REC'D. BY REGISTRAR MAY 22 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Lillian McBrady</i> | |

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